

(a) Possessing red blood discs and fibrin in a much larger proportion.

(b) The mononucleated leucocytes are equal in number, if not in excess, of the multinucleated forms.

(c) The Pneumococcus is present.

I have endeavoured so far to show that closely related clinical signs in the early stages of Acute Pneumonias may be explained very often by a similar distribution of the lesion. We must, of course, always regard these cases as exceptional, the rule being that Acute Pneumonia possesses distinctive signs due to the presence in the blood of pneumotoxin. It is then only when these distinctive subjective symptoms are masked that we are left in doubt. Again, it is quite apparent that for the sake of clearness the use of the terms, lobar, lobular, catarrhal, &c., should be discouraged, and the classification of Acute Pneumonia resolved into

(a) Acute Pneumonia or Pneumonic Fever. Cause—Diplococcus Pneumonia.

(b) Broncho-Pneumonia, including septic form secondary to measles, whooping cough, diphtheria and septic processes.

Regarding the septic forms of Broncho-Pneumonia the inflammation is usually of a septic or spreading type. It may originate in two ways :

(a) By an extension process along the mucous membrane of the bronchioles, the starting point usually being a septic inflammation in the upper air passages or irritation set up by the inhalation of septic gases or particles.

(b) From the presence in the blood of septic organisms, together with the products of their growth and multiplication. The starting point may be a septic inflammation anywhere in the body.

This latter constitutes the pyaemic form of Septic Pneumonia.

Bacterial cause in either case.

Parasitic forms of staphylococci and streptococci.

The lesion in septic forms is extensive, usually starting from a small focus, and extending until nearly the entire lung tissue is involved.

Illustrative of some of the above conditions, I refer briefly